

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040097</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																											
Facility Name: <u>Aurora Rehab & Living Center</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																											
Address: <u>1601 North Farnsworth Avenue</u> <u>Aurora</u> <u>60505</u>																													
<div>NumberCityZip Code</div>																													
County: <u>Kane</u>																													
Telephone Number: <u>(630) 898-1180</u> Fax # <u>(630) 898-1208</u>																													
HFS ID Number: <u>363941735001</u>		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Type or Print Name) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td colspan="2">(Title) _____</td></tr><tr><td colspan="2">(Signed) _____</td></tr><tr><td colspan="2">(Date) _____</td></tr><tr><td colspan="2">(Print Name and Title) <u>Jeffrey K. Singer, C.P.A.</u></td></tr><tr><td colspan="2">Firm Name & Address <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td><td colspan="2"></td></tr><tr><td colspan="2">(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td><td colspan="2"></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</td><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		Paid Preparer	(Title) _____		(Signed) _____		(Date) _____		(Print Name and Title) <u>Jeffrey K. Singer, C.P.A.</u>		Firm Name & Address <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>				(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>				MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001		Phone # (217) 782-1630	
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Date of Initial License for Current Owners: <u>00/00/73</u>																													
Type of Ownership:																													
<table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____					
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	<input type="checkbox"/> Limited Liability Co.																												
	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>																													

SEE ACCOUNTANTS' COMPILATION REPORT

#	0040097	Report Period Beginning:	01/01/05	Ending:	12/31/05
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? Yes

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started **1973**

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
 YES ☒ NO ☐ If YES, enter number
 of beds certified 23 and days of care provided 6,529

Medicare Intermediary Mutual of Omaha

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
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Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 12/31/05 **Fiscal Year:** 12/31/05
*** All facilities other than governmental must report on the accrual basis.**

*** All facilities other than governmental must report on the accrual basis.**

Facility Name & ID Number Aurora Rehab & Living Center # 0040097 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	266,113	63,342	9,503	338,958		338,958		338,958			1
2	Food Purchase		319,250		319,250		319,250	(462)	318,788			2
3	Housekeeping	217,537	24,034		241,571		241,571		241,571			3
4	Laundry	162,828	14,866		177,694		177,694		177,694			4
5	Heat and Other Utilities			198,511	198,511		198,511	(8,143)	190,368			5
6	Maintenance	36,404		72,772	109,176		109,176		109,176			6
7	Other (specify):*											7
8	TOTAL General Services	682,882	421,492	280,786	1,385,160		1,385,160	(8,605)	1,376,555			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,544,948	173,438	184,818	2,903,204		2,903,204		2,903,204			10
10a	Therapy	70,170	205	425	70,800		70,800	7	70,807			10a
11	Activities	129,626	4,775	6,752	141,153		141,153		141,153			11
12	Social Services	111,637		5,095	116,732		116,732		116,732			12
13	CNA Training											13
14	Program Transportation			1,285	1,285		1,285		1,285			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,856,381	178,418	212,775	3,247,574		3,247,574	7	3,247,581			16
	C. General Administration											
17	Administrative	124,390		112,303	236,693		236,693	23,912	260,605			17
18	Directors Fees											18
19	Professional Services			114,013	114,013	(14,523)	99,490	(4,647)	94,843			19
20	Dues, Fees, Subscriptions & Promotions			109,669	109,669		109,669	(43,127)	66,542			20
21	Clerical & General Office Expenses	216,071	38,409	186,314	440,794		440,794	(142,037)	298,757			21
22	Employee Benefits & Payroll Taxes			697,183	697,183		697,183		697,183			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,027	10,027		10,027	(6,466)	3,561			24
25	Other Admin. Staff Transportation			12,023	12,023		12,023	(314)	11,709			25
26	Insurance-Prop.Liab.Malpractice			93,591	93,591		93,591		93,591			26
27	Other (specify):*											27
28	TOTAL General Administration	340,461	38,409	1,335,123	1,713,993	(14,523)	1,699,470	(172,679)	1,526,791			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,879,724	638,319	1,828,684	6,346,727	(14,523)	6,332,204	(181,277)	6,150,927			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			44,520	44,520		44,520	128,439	172,959			30
31	Amortization of Pre-Op. & Org.							4,750	4,750			31
32	Interest			112,684	112,684		112,684	70,054	182,738			32
33	Real Estate Taxes			103,301	103,301	14,523	117,824		117,824			33
34	Rent-Facility & Grounds			723,193	723,193		723,193	(723,193)				34
35	Rent-Equipment & Vehicles			17,587	17,587		17,587	(3,854)	13,733			35
36	Other (specify):*											36
37	TOTAL Ownership			1,001,285	1,001,285	14,523	1,015,808	(523,804)	492,004			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		424,480	417,384	841,864		841,864	7,083	848,947			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,288	101,288		101,288		101,288			42
43	Other (specify):*	70,156			70,156		70,156	(70,156)				43
44	TOTAL Special Cost Centers	70,156	424,480	518,672	1,013,308		1,013,308	(63,073)	950,235			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	3,949,880	1,062,799	3,348,641	8,361,320		8,361,320	(768,154)	7,593,166			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,143)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	42,528	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(462)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,600)	21		18
19	Entertainment	(6,466)	24		19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(132,203)	21		24
25	Fund Raising, Advertising and Promotional	(30,162)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(318)	20		28
29	Other-Attach Schedule	(151,271)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (294,347)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(473,807)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (473,807)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (768,154)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Aurora Rehab & Living Center			
100 0040097			
Report Period Beginning:	01/01/05		
Ending:	12/31/05		
			Sch. V Line
NON-ALLOWABLE EXPENSES			
	Amount	Reference	
1	Miscellaneous Income	\$ (234)	21 1
2	Marketing Salaries	(69,906)	43 2
3	Bank Charges	(1,978)	21 3
4	Franchise Tax	(26)	21 4
5	Bldg Co Management Fees	(24)	17 5
6	COPY Dues	(2,422)	20 6
7	Non-Allowable Auto Lease	(3,854)	38 7
8	Annual Report Fee	(75)	20 8
9	Non-Allowable Employee Recruitment	(9,900)	20 9
10	Non-Allowable Travel Expense	(314)	38 10
11	Related Party Interest	(54,169)	35 11
12	Non-Allowable Legal Retainer	(3,308)	19 12
13	Non-Allowable Legal	(1,339)	19 13
14	Bldg Co Trust Fees	(350)	21 14
15	Bldg Co Franchise Fees	(580)	21 15
16	Bldg Co Bank Charges	(40)	21 16
17	Marketing Salaries	(250)	43 17
18	Bldg Co Professional Fees	(2,730)	19 18
19			19
20			20
21			21
22			22
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96			96
97			97
98			98
99			99
100			100
101	Total	(151,271)	101

Summary A

12/31/05

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		Arlington Rehabilitation and Living Center	Long Grove,	Aurora Account	Highland Park	Building Company
				Simply Rehab	Northbrook	Therapy

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 723,193	Aurora Account	100.00%	\$	\$ (723,193)	1
2	V	32	Interest	199,770	Aurora Account	100.00%		(199,770)	2
3	V	31	Mortgage Costs		Aurora Account	100.00%	4,750	4,750	3
4	V	21	Bank Charges		Aurora Account	100.00%	40	40	4
5	V	30	Depreciation		Aurora Account	100.00%	85,911	85,911	5
6	V	32	Interest		Aurora Account	100.00%	323,993	323,993	6
7	V	19	Professional Fees		Aurora Account	100.00%	2,736	2,736	7
8	V	17	Management Fees		Aurora Account	100.00%	23,936	23,936	8
9	V	21	Franchise Taxes		Aurora Account	100.00%	350	350	9
10	V	21	Trust Fees		Aurora Account	100.00%	350	350	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 922,963			\$ 442,066	\$ * (480,897)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Ancillary Rehab	\$ 416,723	Simply Rehab	100.00%	\$ 423,806	\$ 7,083	15
16	V	10a	Rehab Consulting	425	Simply Rehab	100.00%	432	7	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 417,148			\$ 424,238	\$ * 7,090	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Mann	President	Administrative	10.00%	See Attached	6.60	15.00%	Mgmt Fees	\$ 64,303	17-3	1
2	Patrick Finn	Shareholder	Administrative	4.00%	See Attached	6.60	15.00%	Mgmt Fees	48,000	17-3	2
3	Daniel Mann	Admin. Trainee	Administrative	0.00%	0	24.00	100.00%	Salary	6,407	17-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 118,710		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aurora Rehab & Living Center # 0040097 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 12/31/05

(847)562-0070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Rehab	Direct Allocation						423,806	1
2	10a	Ancillary Rehab	Direct Allocation						432	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 424,238	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aurora Rehab & Living Center # 0040097 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Aurora Rehab & Living Center # 0040097 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Aurora Rehab & Living Center # 0040097 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Aurora Rehab & Living Center # 0040097 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number Aurora Rehab & Living Center # 0040097 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Ending: 12/31/05

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Aurora Account		X	Mortgage			\$	3,415,563			\$	348,111	1
2													2
3													3
4													4
5	See Supplemental Schedule												5
	Working Capital												
6	Banco Popular		X	Line of Credit				725,000				34,398	6
7													7
8	See Supplemental Schedule							28,383					8
9	TOTAL Facility Related						\$	4,168,946			\$	382,509	9
	B. Non-Facility Related*												
10	Glenn Management	X						2,474,128					10
11	Aurora Account	X						334,069					11
12	Venture Fund	X						349,543					12
13	See Supplemental Schedule											(199,771)	13
14	TOTAL Non-Facility Related						\$	3,157,740			\$	(199,771)	14
15	TOTALS (line 9+line14)						\$	7,326,686			\$	182,738	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Note Payable	X					\$	\$ 28,383			\$ 54,169	8
9	Adjusted Off Page 5										(54,169)	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital							28,383				14
	B. Non-Facility Related*											
15	Allocated Int Income						\$	\$			(199,771)	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										(199,771)	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aurora Rehab & Living Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040097

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 15-12-151-040	Long Term Care Property	\$ 84,169.12	\$ 84,169.12
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 84,169.12	\$ 84,169.12

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aurora Rehab & Living Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0040097

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			Tax
Tax Index Number	Property Description	Total Tax	Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,911 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).
None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 47,500 2. Number of Years Over Which it is Being Amortized: 10
3. Current Period Amortization: 4,750 4. Dates Incurred: 1999

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	339,768	1973	\$ 77,514	1
2					2
3	TOTALS	339,768		\$ 77,514	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	14,191		20	710	710	7,425	9
10	Various			1996	16,977		20	849	849	8,155	10
11	Various			1998	35,160		20	1,758	1,758	12,753	11
12	Various			1999	65,009		20	3,251	3,251	22,131	12
13	Various			2000	24,564		20	1,228	1,228	6,689	13
14	Various			2001	46,138		20	2,379	2,379	11,039	14
15											15
16											16
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33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
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61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)	2,484,645	85,911			(85,911)	973,690	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)							68
69	Financial Statement Depreciation		44,520			(44,520)		69
70	TOTAL (lines 4 thru 69)	\$ 2,686,684	\$ 130,431		\$ 10,175	\$ (120,256)	\$ 1,041,882	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,686,684	\$ 130,431		\$ 10,175	\$ (120,256)	\$ 1,041,882	1
2	Elevator Improvement	2002	2,940		20	147	147	576	2
3	Water Heater	2002	1,852		20	185	185	710	3
4	Boiler	2002	10,411		20	868	868	2,820	4
5	Facility Renovation	2002	1,791,005		20	89,550	89,550	320,888	5
6	Air Conditioner	2002	528		20	44	44	165	6
7	Data Lines	2002	784		20	78	78	268	7
8	Fire Security	2002	675		20	96	96	297	8
9	Install New Cable	2002	1,062		20	106	106	345	9
10	Leasehold Improvements	2002	9,600		20	480	480	1,920	10
11	2 Boilers	2003	13,200		20	1,320	1,320	3,190	11
12	Cabling For Wireless System	2003	1,422		20	142	142	367	12
13	Electrical For 3 New Hvac Units	2003	2,285		20	229	229	686	13
14	Generator Repairs	2003	1,110		20	56	56	143	14
15	Plumbing	2003	1,780		20	89	89	267	15
16	Elevator Repairs	2003	1,335		20	67	67	184	16
17	Remodel Resident Rooms	2003	829		20	41	41	93	17
18	Drywall, Tile	2003	708		20	35	35	97	18
19	Carpet	2003	336		20	17	17	46	19
20	Boiler Repairs	2003	632		20	32	32	92	20
21	Valances	2003	1,113		20	56	56	139	21
22	Facility Renovation	2003	433,206		20	21,660	21,660	55,956	22
23	Boiler Repairs	2003	727		20	73	73	152	23
24	Supplies For Remodeling Dining Rooms Wings 3& 4	2004	1,402		20	140	140	280	24
25	Vinyl Flooring For Wing 5 Dining Rm	2004	6,495		20	650	650	1,245	25
26	Wing 5 Remodeling	2004	472		20	47	47	87	26
27	Plumbing Repairs	2004	629		20	63	63	121	27
28	Boiler Repairs	2004	90		20	9	9	17	28
29	Main Entrance Sign	2004	531		20	53	53	97	29
30	Sink	2004	1,232		20	123	123	205	30
31	Sink	2004	1,302		20	130	130	217	31
32	Kitchen System Call	2004	1,464		20	146	146	207	32
33	Landscaping Installation	2004	9,400		20	940	940	1,332	33
34	TOTAL (lines 1 thru 33)		\$ 4,987,241	\$ 130,431		\$ 127,847	\$ (2,584)	\$ 1,435,091	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,987,241	\$ 130,431		\$ 127,847	\$ (2,584)	\$ 1,435,091	1
2	Install Kitchen Call System	2004	1,464		20	146	146	207	2
3	2 Boilers	2004	19,900		20	1,990	1,990	2,488	3
4	Fence	2004	895		20	90	90	112	4
5	Draperies	2004	3,795		20	380	380	474	5
6	Electrical Work	2004	2,210		20	221	221	258	6
7	Fence Materials	2004	1,218		20	122	122	152	7
8	Wiring For New Boilers	2004	310		20	31	31	34	8
9	Wiring For New Boilers	2004	408		20	41	41	44	9
10	Fence & Fan Insatllation	2004	775		20	78	78	90	10
11	Ceramic Tile & Installation	2004	5,337		20	534	534	978	11
12	Electrical Work	2004	1,534		20	153	153	166	12
13	Wander Guard Transmitters	2005	2,826		20	71	71	71	13
14	Boiler Pumps & Draft Inducer	2005	2,118		20	106	106	106	14
15	Boiler Repairs	2005	1,342		20	62	62	62	15
16	Gas Supply To Boiler	2005	3,250		20	149	149	149	16
17	Louver & Damper Installation	2005	1,600		20	60	60	60	17
18	Replace Gas Valve & Damper Motor	2005	1,079		20	40	40	40	18
19	Door Closers	2005	529		20	20	20	20	19
20	Spring Hinges	2005	890		20	33	33	33	20
21	Wander Guard System	2005	10,059		20	335	335	335	21
22	Code Alert System Install	2005	1,890		20	47	47	47	22
23	Doors	2005	4,765		20	139	139	139	23
24	Code Alert Installation	2005	1,520		20	44	44	44	24
25	Relocate & Install Pull Stations	2005	2,600		20	76	76	76	25
26	Emergency Battery Backup Lighting	2005	1,105		20	28	28	28	26
27	Oxygen Storage Buildings	2005	2,740		20	69	69	69	27
28	Replace Fire Alarm System	2005	3,024		20	76	76	76	28
29	Doors	2005	800		20	20	20	20	29
30	Smoke Detectors	2005	954		20	24	24	24	30
31	Vinyl Flooring	2005	15,495		20	323	323	323	31
32	Vinyl Flooring Adhesive & Reducer Strips	2005	649		20	14	14	14	32
33	A/C Repairs	2005	2,291		20	57	57	57	33
34	TOTAL (lines 1 thru 33)		\$ 5,086,613	\$ 130,431		\$ 133,426	\$ 2,995	\$ 1,441,887	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$5,086,613	\$130,431		\$133,426	\$2,995	\$1,441,887	1
2	Flooring	2005	4,870		20	81	81	81	2
3	Vinyl Flooring	2005	5,692		20	95	95	95	3
4	Inducer Assembly	2005	1,321		20	22	22	22	4
5	Remodel Therapy Room	2005	1,160		20	15	15	15	5
6	New Tile Flooring	2005	1,718		20	21	21	21	6
7	New Door	2005	1,680		20	21	21	21	7
8	New Tile, Bathroom Fixtures	2005	2,389		20	10	10	10	8
9	Magnetic Exit Locks / Fire Alarm Connect	2005	2,868		20	12	12	12	9
10	New Tile, Bathroom Fixtures	2005	1,694		20	7	7	7	10
11	Flooring Project	2005	1,440		20	6	6	6	11
12	New Tile Flooring	2005	2,656		20	22	22	22	12
13	Carpet Tiles	2005	824		20	27	27	27	13
14	Air Conditioners	2005	1,518		20	44	44	44	14
15									15
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	1
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4									4
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$5,116,443	\$130,431		\$133,809	\$3,378	\$1,442,270	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 5,116,443	\$ 130,431		\$ 133,809	\$ 3,378	\$ 1,442,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,116,443	\$ 130,431		\$ 133,809	\$ 3,378	\$ 1,442,270	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 5,116,443	\$ 130,431		\$ 133,809	\$ 3,378	\$ 1,442,270	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,116,443	\$ 130,431		\$ 133,809	\$ 3,378	\$ 1,442,270	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1973	1962	\$ 973,690	\$		\$	\$	\$ 973,690	4
5				1976	637,909	62,448			(62,448)		5
6				1983	35,661						6
7				1984	9,486						7
8				1985	2,338						8
	Improvement Type**										
9											9
10				1994	67,225	1,724			(1,724)		10
11				1993	10,887	284			(284)		11
12				1992	4,332	38			(38)		12
13				1991	39,929	1,268			(1,268)		13
14				1990	137,077	4,145			(4,145)		14
15				1988	10,040	320			(320)		15
16				1987	106,312	3,374			(3,374)		16
17				1986	236,734	12,310			(12,310)		17
18				1985	25,102						18
19				1984	22,377						19
20				1983	10,020						20
21				1982	49,137						21
22				1981	4,175						22
23				1980	31,412						23
24				1979	35,255						24
25				1978	16,968						25
26				1977	16,093						26
27				1973	2,486						27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$2,484,645	\$85,911		\$	\$(85,911)	\$973,690	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$253,302	\$	\$32,764	\$32,764	10	\$130,776	71
72	Current Year Purchases	67,459		4,406	4,406	10	4,406	72
73	Fully Depreciated Assets	82,117				10	82,117	73
74								74
75	TOTALS	\$402,878	\$	\$37,170	\$37,170		\$217,299	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	TRUCK	1998	\$16,564	\$	\$	\$	5	\$16,563	76
77	Facility	BUS	1999	68,151		426	426	5	67,003	77
78	Facility	1/4 JEEP FOR TERRY BATHUN	2004	2,700		540	540	5	900	78
79	Facility	1997 JEEP GRAND CHEROKEE	2005	6,079		1,014	1,014	5	1,014	79
80	TOTALS			\$93,494	\$	\$1,980	\$1,980		\$85,480	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$5,690,329	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$130,431	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$172,959	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$42,528	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,745,049	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Building Company CIP	\$349,543	92
93			93
94			94
95		\$349,543	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 10,809 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	Car Lease	\$ 478.33	\$ 2,924	17
18					18
19					19
20					20
21	TOTAL		\$ 478.33	\$ 2,924	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 194,160	\$		\$ 194,160	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			32,277			32,277	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			190,847			190,847	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				222,493		222,493	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					100	201,987		202,087	13
14	TOTAL			\$		\$ 417,384	\$ 424,480		\$ 841,864	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (73,250)	\$ (24,922)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,798,754	1,798,754	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,031	63,031	6
7	Other Prepaid Expenses	2,427	2,427	7
8	Accounts Receivable (owners or related parties)	120,746	120,746	8
9	Other(specify): <u>See Attached Schedule</u>	6,574	6,574	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,918,282	\$ 1,966,610	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		77,514	13
14	Buildings, at Historical Cost		1,611,598	14
15	Leasehold Improvements, at Historical Cost	574,140	2,601,725	15
16	Equipment, at Historical Cost	434,313	434,313	16
17	Accumulated Depreciation (book methods)	(410,124)	(2,252,022)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		5,090,871	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 598,329	\$ 7,563,999	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,516,611	\$ 9,530,609	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 516,480	\$ 516,480	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(29)	(29)	28
29	Short-Term Notes Payable	1,059,069	1,059,069	29
30	Accrued Salaries Payable	94,730	94,730	30
31	Accrued Taxes Payable (excluding real estate taxes)	67,748	67,748	31
32	Accrued Real Estate Taxes(Sch.IX-B)	88,378	88,378	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	965,524	993,906	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,791,900	\$ 2,820,282	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	28,382	2,852,053	39
40	Mortgage Payable		3,415,564	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 28,382	\$ 6,267,617	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,820,282	\$ 9,087,899	46
47	TOTAL EQUITY(page 18, line 24)	\$ (303,671)	\$ 442,710	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,516,611	\$ 9,530,609	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (157,995)	1
2	Restatements (describe):		2
3	Expense Restatement	(5,795)	3
4	Rounding	9	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (163,781)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	203,110	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(343,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (139,890)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (303,671)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aurora Rehab & Living Center # 0040097 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,019,063	1
2	Discounts and Allowances for all Levels	1,009,044	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,028,107	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	238,697	6
7	Oxygen	37,579	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 276,276	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	218,435	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,976	19
20	Radiology and X-Ray		20
21	Other Medical Services	23,402	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 259,813	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	234	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 234	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,564,430	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,385,160	31
32	Health Care	3,247,574	32
33	General Administration	1,713,993	33
	B. Capital Expense		
34	Ownership	1,001,285	34
	C. Ancillary Expense		
35	Special Cost Centers	912,020	35
36	Provider Participation Fee	101,288	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,361,320	40
41	Income before Income Taxes (line 30 minus line 40)**	203,110	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 203,110	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,786	2,014	\$ 70,914	\$ 35.21	1
2	Assistant Director of Nursing	1,761	1,966	60,631	30.84	2
3	Registered Nurses	27,469	29,170	875,730	30.02	3
4	Licensed Practical Nurses	11,844	12,071	317,698	26.32	4
5	CNAs & Orderlies	98,788	104,237	1,193,794	11.45	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,628	5,014	70,170	13.99	8
9	Activity Director	1,921	2,086	26,191	12.56	9
10	Activity Assistants	10,409	10,950	103,435	9.45	10
11	Social Service Workers	6,442	7,041	111,637	15.86	11
12	Dietician					12
13	Food Service Supervisor	1,977	2,262	36,230	16.02	13
14	Head Cook	3,569	3,853	42,303	10.98	14
15	Cook Helpers/Assistants	21,749	23,369	187,580	8.03	15
16	Dishwashers					16
17	Maintenance Workers	2,113	2,214	36,404	16.44	17
18	Housekeepers	19,501	21,475	217,537	10.13	18
19	Laundry	17,483	19,202	162,828	8.48	19
20	Administrator	3,835	4,227	113,247	26.79	20
21	Assistant Administrator	821	978	11,143	11.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,756	14,060	216,071	15.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,967	2,053	26,181	12.75	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	2,057	2,166	70,156	32.39	33
34	TOTAL (lines 1 - 33)	252,876	270,408	\$ 3,949,880 *	\$ 14.61	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	239	\$ 9,503	01-03	35
36	Medical Director	Monthly	14,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	282	8,670	10-03	38
39	Pharmacist Consultant	Monthly	3,348	10-03	39
40	Physical Therapy Consultant	3	157	10a-03	40
41	Occupational Therapy Consultant	3	168	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	100	10a-03	43
44	Activity Consultant	127	6,752	11-03	44
45	Social Service Consultant	82	4,605	12-03	45
46	Other(specify) Psych Consultant	10	490	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	748	\$ 48,193		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	952	\$ 43,693	10-03	50
51	Licensed Practical Nurses	3,592	129,107	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	4,544	\$ 172,800		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Diane Kramer (1/1-2/1/05)	Administrator	0	\$ 13,386
Brian Celerio (3/7-12/31/05)	Administrator	0	42,474
Karen Christner	Exec Director	0	57,387
Stacy Hiles-Jank	Asst. Admin	0	4,736
Daniel Mann	Asst. Admin	0	6,407
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 124,390
B. Administrative - Other			
Description			Amount
Senior Living Consultants - Management Fees		\$	64,303
Resource Consulting - Management Fees			48,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$	112,303
C. Professional Services			
Vendor/Payee	Type		Amount
FR&R	Accounting	\$	21,375
Camile J Koehl & Assoc.	Accounting		327
Talx Corp	Unemployment Consulting		350
Personnel Planners	Unemployment Consulting		366
HDSI	Data Processing		5,535
Computer Business Services	Computer Services		2,158
Global Exchange Services	Computer Services		1,459
American Data	Computer Services		3,335
CDW	Computer Services		2,116
Kluber, Skahan & Assoc	Architect Fees		5,000
Real Estate Analysis Corp	Real Estate Appraisal		6,500
See Supplemetal Schedule			65,492
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$	114,013
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	103,185
Unemployment Compensation Insurance			78,470
FICA Taxes			301,942
Employee Health Insurance			150,225
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Benefits			14,001
401K Matching Expense			1,887
Pension Expense			47,473
TOTAL (agree to Schedule V, line 22, col.8)		\$	697,183
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
	11237		
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	2,850
Advertising: Employee Recruitment			41,650
Health Care Worker Background Check (Indicate # of checks performed 105)			1,680
Dues ICLTC			7,867
Dues and Subscriptions			4,077
Licenses and Fees			8,418
Advertising and Promotional			30,480
Less: Public Relations Expense (
Non-allowable advertising			(30,162)
Yellow page advertising			(318)
TOTAL (agree to Sch. V, line 20, col. 8)		\$	66,542
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			3,561
Entertainment Expense (
TOTAL (agree to Sch. V, line 24, col. 8)		\$	3,561

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
Yes-ICLTC \$10289
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

Yes
Yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
10 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$34,783Line10-2
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
- (9)

Are you presently operating under a sublease agreement?

YESXNO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YESNOX
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$101,288
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$0
N/A
- (16)

Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents?
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
No
100% ln 14
Yes
Yes
N/A
No
- (17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

No
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

Yes

SEE ACCOUNTANTS' COMPILATION REPORT